		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037606

Facility Name: Hampton Plaza Healthcare Center

Address: 9777 Greenwood (Number) Niles (City) 60648 (Zip Code)

County: Cook

Telephone Number: (847) 470-0000 **Fax #** (847) 967-5462

IDPA ID Number: 363769397001

Date of Initial License for Current Owners: 02/13/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	x	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3	154	Intermediate (ICF)	154	56,364	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	304	TOTALS	304	111,264	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,620	4,495	4,916	35,031	8
9	SNF/PED					9
10	ICF	42,401	4,253	1,175	47,829	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,021	8,749	6,091	82,860	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.47%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 11/01/91

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 11/01/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 33 and days of care provided 3,219

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7 **	8	9	10	
1	Dietary	447,287	54,481	12,427	514,195		514,195		514,195			1
2	Food Purchase		425,059		425,059		425,059	(54,138)	370,921			2
3	Housekeeping	401,161	46,935		448,096		448,096	(34,981)	413,115			3
4	Laundry	153,236	35,113		188,349		188,349		188,349			4
5	Heat and Other Utilities			222,026	222,026		222,026		222,026			5
6	Maintenance	89,109		175,958	265,067		265,067	2,246	267,313			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,090,793	561,588	410,411	2,062,792		2,062,792	(86,873)	1,975,919			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	3,362,492	194,213	55,065	3,611,770		3,611,770	90,136	3,701,906			10
10a	Therapy			184,333	184,333		184,333		184,333			10a
11	Activities	110,035		15,703	125,738		125,738		125,738			11
12	Social Services	95,833		3,945	99,778		99,778		99,778			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,568,360	194,213	280,646	4,043,219		4,043,219	90,136	4,133,355			16
	C. General Administration											
17	Administrative	123,813		658,468	782,281		782,281	(658,468)	123,813			17
18	Directors Fees											18
19	Professional Services			351,090	351,090		351,090	(43,276)	307,814			19
20	Dues, Fees, Subscriptions & Promotions			59,840	59,840		59,840	(2,425)	57,415			20
21	Clerical & General Office Expenses	264,937	53,001	59,753	377,691		377,691	12,659	390,350			21
22	Employee Benefits & Payroll Taxes			726,202	726,202		726,202	35,414	761,616			22
23	Inservice Training & Education			906	906		906		906			23
24	Travel and Seminar			2,720	2,720		2,720		2,720			24
25	Other Admin. Staff Transportation			6,354	6,354		6,354	(3,604)	2,750			25
26	Insurance-Prop.Liab.Malpractice			128,124	128,124		128,124	(9,358)	118,766			26
27	Other (specify):*											27
28	**TOTAL General Administration**	388,750	53,001	1,993,457	2,435,208		2,435,208	(669,058)	1,766,150			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,047,903	808,802	2,684,514	8,541,219		8,541,219	(665,795)	7,875,424			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Hampton Plaza Healthcare Center #0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			90,205	90,205		90,205	304,214	394,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,120,195	1,120,195			32
33	Real Estate Taxes			435,199	435,199		435,199		435,199			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			57,050	57,050		57,050	4,042	61,092			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,442,454	2,442,454		2,442,454	(431,549)	2,010,905			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,151		112,151		112,151		112,151			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,896	166,896		166,896		166,896			42
43	Other (specify):* Nonallowable costs			492,841	492,841		492,841	(492,841)				43
44	**TOTAL Special Cost Centers**		112,151	659,737	771,888		771,888	(492,841)	279,047			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,047,903	920,953	5,786,705	11,755,561		11,755,561	(1,590,185)	10,165,376			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	32,273	30		9
10	Interest and Other Investment Income	(55,564)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,504)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(9,358)	26		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,551)	43		18
19	Entertainment				19
20	Contributions	(15,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(40,727)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(336,838)	43		24
25	Fund Raising, Advertising and Promotional	(56,755)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	773	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(199,730)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (707,481)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(882,704)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (882,704)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,590,185)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Hampton Plaza Healthcare Center

ID# 0037606

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Amortization Expense-Painting/Decorating	$ 4,265	6	1
2	Dues & Subscriptions	(2,799)	20	2
3	Housekeeping Salaries	(36,760)	3	3
4	Physician	(404)	43	4
5	Travel & Meetings	(2,419)	43	5
6	Patient Clothing	(1,117)	43	6
7	Loss on investments	(56,641)	43	7
8	Office Consultant-related party	(36,667)	21	8
9	Office Expense-related party	(15,300)	21	9
10	Food-related party	(23,050)	2	10
11	Medical Supplies-related party	(16,269)	10	11
12	Capitalized Repairs and Maintenance	(2,969)	6	12
13	Disallow Dental Consultant	(9,600)	43	13
14				14
15				15
16				16
17				17
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(199,730)		90

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Behr Family Partnership	36.25%			Hampton Plaza Health Care Center Real		
Geiser Family LLC	38.25%			Estate Limited Partnership		
Goldberg Family Ltd. Pship No. 1	20.00%				Niles	Real Estate Co.
Burton Behr	4.50%					
Lindsay J., Inc.	1.00%			LLW Management Co	Niles	Management Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Office Expenses	$	Hampton Plaza Health Care Center Real Estate Limited Pship	100.00%	$ 53	$ 53	1
2	V	30	Depreciation		Hampton Plaza Health Care Center Real Estate Limited Pship	100.00%	271,941	271,941	2
3	V	32	Interest Expense	17	Hampton Plaza Health Care Center Real Estate Limited Pship	100.00%	1,175,776	1,175,759	3
4	V	33	Property Taxes	435,199	Hampton Plaza Health Care Center Real Estate Limited Pship	100.00%	435,199		4
5	V	34	Rent	1,860,000	Hampton Plaza Health Care Center Real Estate Limited Pship	100.00%		(1,860,000)	5
6	V	43	Replacement Tax	773	Hampton Plaza Health Care Center Real Estate Limited Pship	100.00%		(773)	6
7	V	43	Penalties		Hampton Plaza Health Care Center Real Estate Limited Pship	100.00%	10,889	10,889	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,295,989			$ 1,893,858	$ * (402,131)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$	LLW Management Co.	100.00%	$ 101,830	$ 101,830	15
16	V	17	Management Fee	658,468	LLW Management Co.	100.00%		(658,468)	16
17	V	21	Office Expense		LLW Management Co.	100.00%	55,267	55,267	17
18	V	22	Employee Benefits		LLW Management Co.	100.00%	4,700	4,700	18
19	V	25	Vehicle Expense		LLW Management Co.	100.00%	2,750	2,750	19
20	V	35	Equipment Rental		LLW Management Co.	100.00%	13,348	13,348	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 658,468			$ 177,895	$ * (480,573)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Burton Behr & Family	Owner	Administrative	41.25%	None	40+	100.00%	Salary	$ 60,000	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 60,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		x	Mortgage note payable	Varies	07/01/98	$ 14,400,000	$ 13,940,790	07/01/08	0.0884	$ 1,090,588	1
2	Parkway		x	Line of credit	Varies	01/01/00	200,000	200,000	05/31/01	0.0900	8,471	2
3												3
4												4
5												5
	Working Capital											
6	Parkway		x	Line of credit	Varies	09/15/99	500,000	18,100	09/15/00	0.1050	55,086	6
7	Loan from Partner	x		Working Capital	Varies	06/30/00	80,000	80,000	demand			7
8												8
9	TOTAL Facility Related						$ 15,180,000	$ 14,238,890			$ 1,154,145	9
	B. Non-Facility Related*											
10								Amortization Expense			21,631	10
11								Interest Income Offset			(55,581)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (33,950)	14
15	TOTALS (line 9+line14)						$ 15,180,000	$ 14,238,890			$ 1,120,195	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 483,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 448,199	2
3. Under or (over) accrual (line 2 minus line 1).		$ (34,801)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 470,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 435,199	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	354,368	8
	1996	359,536	9
	1997	415,919	10
	1998	442,140	11
	1999	448,199	12

1999 2nd installment total	227,133	Est year tax	454,266	
Two payments	2	3% increase	1.03	
Est year tax	454,266	Est 2000 tax	467,894	use 470,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,000 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	253,082	1991	$ 1,500,514	1
2					2
3	TOTALS	253,082		$ 1,500,514	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	304		1991	1975	$ 5,040,000	$	40	$ 126,000	$ 126,000	$ 1,155,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1990	170,622		10-35	5,710	5,710	59,955	9
10	Leasehold Improvements			1991	5,558	84	10-35	316	232	3,001	10
11	Leasehold Improvements			1992	185,548	4,639	40	4,639		39,430	11
12	Leasehold Improvements			1992	185,987		40	4,650	4,650	39,525	12
13	Leasehold Improvements			1993	202,758	5,206	40	5,069	(137)	38,360	13
14	Leasehold Improvements			1994	50,935	1,273	40	1,273		8,275	14
15	Leasehold Improvements			1995	45,690	1,142	40	1,142		6,281	15
16	Satellite TV System and wiring			1996	24,550	614	40	614		2,763	16
17	Roof repairs			1996	7,310	183	40	183		823	17
18	Installation of lighting and shelving			1996	2,979	74	40	74		333	18
19	Compressor repairs			1996	4,000	100	40	100		450	19
20	Boiler repairs			1996	10,000	250	40	250		1,125	20
21	Boiler repairs			1997	13,841	346	40	346		1,211	21
22	Compressor repairs			1997	7,415	185	40	185		648	22
23	Fire dampers & intake door			1997	6,211	155	40	155		543	23
24	Kitchen & laundry remodeling			1997	11,963	299	40	299		1,047	24
25	Windows & sprinkler heads			1997	3,870	97	40	97		339	25
26	Built-in washers			1997	53,498	1,337	40	1,337		4,680	26
27	Fire dampers			1998	7,568	190	40	190		475	27
28	Alarm System			1998	2,545	64	40	64		160	28
29	Air Handler			1998	7,063	176	40	176		440	29
30	Compressor repairs			1998	6,871	172	40	172		430	30
31	Heating & Cooling Coil			1998	2,955	74	40	74		185	31
32	Generator			1998	1,375	34	40	34		85	32
33	Hot Water Control			1998	1,719	42	40	42		105	33
34	Gas Piping			1998	620	16	40	16		40	34
35											35
36	TOTAL (lines 4 thru 35)				$ 6,063,451	$ 16,752		$ 153,207	$ 136,455	$ 1,365,709	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Metal Door			1998	969	24	40	24		60	9
10	Landscaping			1998	7,500	188	40	188		470	10
11	Door Closer			1998	1,000	26	40	26		65	11
12	Boiler			1998	1,717	42	40	42		105	12
13	Lighting & Fixtures			1999	3,021	76	40	76		114	13
14	Wall Repair, Guards and Panels			1999	19,596	490	40	490		735	14
15	Electrical Switches & Wiring			1999	20,648	516	40	516		774	15
16	Flooring			1999	8,850	221	40	221		332	16
17	Sewer & Piping			1999	5,480	137	40	137		206	17
18	Window Tint			1999	633	16	40	16		24	18
19	Condensor Repairs, Replacement & Fans			1999	15,280	382	40	382		573	19
20	Vent System Laundry Room			1999	3,360	84	40	84		126	20
21	Compressor			1999	19,938	498	40	498		747	21
22	Remodeling 1st Floor Hall & Parlor			1999	3,472	87	40	87		130	22
23	Elevator Flooring			1999	1,748	44	40	44		66	23
24	Pump Repair			1999	5,455		40	136	136	204	24
25	Air Filter			1999	3,607	90	40	90		135	25
26	Boiler Repair			2000	11,831	148	40	148		148	26
27	Compressor Repair			2000	4,693	59	40	59		59	27
28	Hot Water Heater Repair			2000	3,328	42	40	42		42	28
29	Generator			2000	1,375	17	40	17		17	29
30	5th Floor Remodel			2000	12,485	156	40	156		156	30
31	Elevator Telephones			2000	11,199	140	40	140		140	31
32	3rd Floor Remodel			2000	9,870	123	40	123		123	32
33	Basement Repairs			2000	1,337	17	40	17		17	33
34	Eyewash Install, HVAC Repair			2000	1,081	14	40	14		14	34
35											35
36	TOTAL (lines 4 thru 35)				$ 179,473	$ 3,637		$ 3,773	$ 136	$ 5,582	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cable Dish			2000	900	11	40	11		11	9
10	B&G install			2000	2,348	29	40	29		29	10
11	A/C online			2000	2,335	29	40	29		29	11
12	Automatic Door Repair			2000	1,563	20	40	20		20	12
13	Window Repairs			2000	4,695	59	40	59		59	13
14	Carpeting			2000	13,646	171	40	171		171	14
15											15
16											16
17	Leasehold Improvements per 1991 Medicaid audit			1991	107,191		40	2,680	2,680	25,460	17
18											18
19	Allocated from Real Estate Psp.-new building										19
20	New addition			1997	1,584,707		40	39,619	39,619	138,666	20
21	New sign			1997	6,995		40	175	175	612	21
22	2nd floor remodeling			1997	97,447		40	2,436	2,436	8,526	22
23	1st floor remodeling			1997	160,254		40	4,006	4,006	14,021	23
24	capitalized interest			1997	15,600		40	390	390	1,365	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,997,681	$ 319		$ 49,625	$ 49,306	$ 188,969	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,826,427	$ 166,708	$ 185,716	$ 19,008	5-10 yrs	$ 1,504,921	37
38	Current Year Purchases	20,979	2,098	2,098		5	2,098	38
39	Fully Depreciated Assets	8,532					8,532	39
40								40
41	TOTALS	$ 1,855,938	$ 168,806	$ 187,814	$ 19,008		$ 1,515,551	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 11,597,057	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 189,514	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 394,419	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 204,905	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,075,811	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: See Page 6, Schedule VII

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 27,249 Description: Washer/Dryer $4,800; Storage $9,139; Postage Meter $584; Water $289; Copier $12,437
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1999 Ford Van	$ 625.00	$ 7,500	17
18	Resident Care	1998 Dodge Van	810.00	9,720	18
19	Resident Care	1999 Chevy Van	775.00	3,275	19
20	Allocated from Management Company			13,348	20
21	TOTAL		$ 2,210.00	$ 33,843	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a. C3	hrs	$	4,906	$ 71,404	$	4,906	$ 71,404	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		518	9,585		518	9,585	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3	hrs		6,433	97,319		6,433	97,319	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				80,799		80,799	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Schedule 16A	L39, C2					31,352		31,352	13
14	TOTAL			$	11,857	$ 178,308	$ 112,151	11,857	$ 290,459	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Hampton Plaza Health Care Center Oper. Ltd. Ptp.
Provider No: #0037606
FYE 12/31/2000

XIV. Special Services — Schedule 16A
Line 13-Other (specify)

	Supplies
Laboratory	342
Radiology	3,407
Infusion Services	27,603
Total	31,352

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$ 4,144	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,000)	2,311,057	2,311,057	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,332	121,332	6
7	Other Prepaid Expenses	713,223	713,223	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached Schedule 17A		88,489	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,146,612	$ 3,238,245	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	39,135	39,135	12
13	Land		1,500,514	13
14	Buildings, at Historical Cost		5,040,000	14
15	Leasehold Improvements, at Historical Cost	869,627	3,200,605	15
16	Equipment, at Historical Cost	620,846	1,855,938	16
17	Accumulated Depreciation (book methods)	(595,128)	(3,075,811)	17
18	Deferred Charges		7,533	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Mortgage Costs		162,233	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 934,480	$ 8,730,147	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,081,092	$ 11,968,392	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 921,069	$ 931,958	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	99,703	99,703	28
29	Short-Term Notes Payable	80,000	298,100	29
30	Accrued Salaries Payable	518,891	518,891	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		470,000	32
33	Accrued Interest Payable		272,335	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third-Party Payor	33,233	33,233	36
37	Due to Related Party	700,000	700,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,352,896	$ 3,324,220	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,940,790	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,940,790	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,352,896	$ 17,265,010	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,728,196	$ (5,296,618)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,081,092	$ 11,968,392	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Hampton Plaza Health Care Center Oper. Ltd. Ptp.
Provider No: #0037606
FYE 12/31/2000

XV. Balance Sheet Schedule 17A

A. Current Assets Line 9-Other Current Assets	Operating	After Consolidation
Real Estate Tax Escrow	0	88,254
Insurance Escrow	0	235
Total line 9	0	88,489

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,471,617	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,471,617	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,453,038)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Write off unrealized loss on investments sold	55,590	15
16	Other (describe) Partners' Capital Contribution	1,654,027	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 256,579	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,728,196	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,119,574	1
2	Discounts and Allowances for all Levels	(760,783)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,358,791	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	345,492	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 345,492	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	28	15
16	Rental of Facility Space		16
17	Sale of Drugs	103,573	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,562	20
21	Other Medical Services	341,198	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 449,361	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55,564	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 55,564	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Patient Income	93,315	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 93,315	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,302,523	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,062,792	31
32	Health Care	4,043,219	32
33	General Administration	2,435,208	33
	B. Capital Expense		
34	Ownership	2,442,454	34
	C. Ancillary Expense		
35	Special Cost Centers	604,992	35
36	Provider Participation Fee	166,896	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,755,561	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,453,038)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,453,038)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,902	2,086	$ 63,816	$ 30.59	1
2	Assistant Director of Nursing	1,613	1,888	50,992	27.01	2
3	Registered Nurses	51,076	56,770	1,148,482	20.23	3
4	Licensed Practical Nurses	14,497	16,219	265,599	16.38	4
5	Nurse Aides & Orderlies	132,319	141,094	1,621,185	11.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,869	1,978	30,843	15.59	9
10	Activity Assistants	11,494	12,207	79,192	6.49	10
11	Social Service Workers	6,232	6,767	95,833	14.16	11
12	Dietician	1,949	2,086	38,871	18.63	12
13	Food Service Supervisor					13
14	Head Cook	4,993	5,687	59,688	10.50	14
15	Cook Helpers/Assistants	44,465	48,009	348,728	7.26	15
16	Dishwashers					16
17	Maintenance Workers	6,665	7,081	89,109	12.58	17
18	Housekeepers	43,952	46,903	401,161	8.55	18
19	Laundry	17,479	19,252	153,236	7.96	19
20	Administrator	1,712	2,160	63,813	29.54	20
21	Assistant Administrator					21
22	Other Administrative	2,000	2,080	60,000	28.85	22
23	Office Manager					23
24	Clerical	14,238	15,895	264,937	16.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,981	2,246	44,136	19.65	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,661	3,002	34,221	11.40	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coordinators	5,622	6,210	134,061	21.59	33
34	TOTAL (lines 1 - 33)	368,719	399,620	$ 5,047,903 *	$ 12.63	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	292	$ 12,427	L1, C3	35
36	Medical Director	96	21,600	L9, C3	36
37	Medical Records Consultant	112	4,704	L10, C3	37
38	Nurse Consultant	347	17,350	L10, C3	38
39	Pharmacist Consultant	44	2,500	L10, C3	39
40	Physical Therapy Consultant	69	3,400	L10a, C3	40
41	Occupational Therapy Consultant	52	2,625	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,597	L11, C3	44
45	Social Service Consultant	81	3,945	L12, C3	45
46	Other(specify)				46
47	Quality Assurance Consultant	Monthly	450	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,146	$ 71,598		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,777	30,061	L10, C3	52
53	TOTAL (lines 50 - 52)	1,777	$ 30,061		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carroll Terrill	Administrative	0.00%	$ 63,813
Burton Behr	Administrative	41.25%	60,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 123,813

B. Administrative - Other

Description	Amount
Management Fee (eliminated in column 7)	$ 658,468
TOTAL (agree to Schedule V, line 17, col. 3)	$ 658,468
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnal Planners	U/C Consultant	$ 855
John Clarke	Personnel Consulting	10
Fagel & Haber	Nurse Petition	467
Achieve Accreditation	JCAHO Consulting	5,660
American Express Tax & Bus Svc.	Accounting	36,469
Schwartz & Freeman	Legal	21,917
Richard P. Soro, P.C.	Legal	2,160
Altschuler, Melvoin & Glasser LLP	Accounting	19,362
Duane, Morris & Heckscher LLP	Legal	211,478
Illinois Appraisal Services, Inc.	Business Appraisal	7,500
BDO Seidman LLP	Accounting	15,000
See attached schedule 21A		30,212
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 351,090

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,598
Unemployment Compensation Insurance	35,885
FICA Taxes	376,477
Employee Health Insurance	120,073
Employee Meals	31,088
Illinois Municipal Retirement Fund (IMRF)*	
Laboratory Fees	718
Casualty Claims	3,044
Union, Health & Welfare	114,733
TOTAL (agree to Schedule V, line 22, col.8)	$ 761,616

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
n/a		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,056
Health Care Worker Background Check	
(Indicate # of checks performed 31)	374
Miscellaneous Licenses & Permits	5,214
Illinois Health Care Association Dues	8,424
Illinois Council on Long Term Care	12,600
Miscellaneous Dues	11,790
Miscellaneous Publications	1,957
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,415

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,720
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,720

* Attach copy of IMRF notifications

**See instructions.

Hampton Plaza Health Care Center Oper. Ltd. Ptp.
Provider NO: #0037606
FYE 12/31/2000

XIX. Support Services — Schedule 21A
C. Professional Services

Vendor/Payee	Type	Amount
Earth Release	Ground Consulting	950
Buster Creative	Printing	1,599
HDSI	Computer Services	9,795
AdminaStar	Computer Services	1,000
Integrated Inventory	Computer Services	2,375
Accu-Med Services	Billing/Computer Services	2,248
MaxxSource	Billing Services	1,200
Systematic Management Systems	Blood Glucose	11,045
		30,212

Non-allowable Legal Fees

Earth Release	950
Buster Creative	1,599
Schwartz & Freeman	3,725
Duane, Morris & Heckscher LLP	12,342
BDO Seidman LLP	15,000
Illinois Appraisal Services, Inc.	7,500
Richard P. Sora, P.C.	2,160
	43,276

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maintenance	1997	$ 1,628	3 yrs	$ 271	$ 543	$ 543	$ 271	$	$	$	$	$
2	Painting/Decorating	1997	751	3 yrs	125	250	250	126					
3	Painting/Decorating	1999	10,119	3 yrs			1,687	3,373	3,373	1,686			
4	Painting/Decorating	2000	2,969	3 yrs				495	990	990	494		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 15,467		$ 396	$ 793	$ 2,480	$ 4,265	$ 4,363	$ 2,676	$ 494	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Plaza Healthcare Center # 0037606 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $8,424**
Illinois Council on Long Term Care $12,600

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,709** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **166,896**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **31,088** Has any meal income been offset against related costs? **No** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ n/a

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **n/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.